



Office of the Ohio Public Defender  
8 East Long Street  
Columbus, Ohio 43215-2998  
(614) 466-5394  
FAX NUMBER: (614) 728-3670

### AUTHORIZATION TO RELEASE INFORMATION

TO: Dr. Terry Swartz  
8180 Corporate Pk Dr.  
Suite 104  
Cincinnati, OH 45242

RE: State of Ohio v. Lee E. Moore  
  
DATE: 11/17/99

You are hereby authorized to release to the Office of the Ohio Public Defender all records or other documents currently in your possession. Their representative may examine and make copies of all of my medical, psychological, hospital, police, and employment records, or any other records he/she may deem necessary in his/her work on my behalf. You are authorized to discuss these records and any other matters concerning me with said representative and are asked to assist him/her on the current investigation.

This authorization includes release of information concerning background, testing, and treatment of drug and alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV).

WITNESS:

Lynne K. Lane

Lee E. Moore  
Client's Signature



Office of the Ohio Public Defender  
8 East Long Street  
Columbus, Ohio 43215-2998  
(614) 466-5394  
FAX NUMBER: (614) 644-9972

DAVID H. BODIKER  
State Public Defender

Date Rec'd \_\_\_\_\_

1st Follow-up \_\_\_\_\_

2nd Follow-up \_\_\_\_\_

November 17, 1999

Dr. Terry Swartz  
8180 Corporate Park Dr.  
Suite #104  
Cincinnati, Ohio 45242

Re: State of Ohio v. Lee E. Moore

Dear Sir:

Please be advised that the Ohio Public Defender is representing **Lee E. Moore** in the above referenced matter. The information requested herein is necessary for a detailed social history to be completed on his behalf.

In our efforts to properly represent **Mr. Moore** we are requesting that you provide us with any and all *psychiatric records* regarding **Mr. Moore**. These records should include, but are not limited to:

Psychiatric

- date(s) of evaluation;
- tests administered;
- interview reports;
- case notes;
- collateral information used, i.e., medical reports, school records, interviews with friends and/or family, etc.;
- diagnosis;
- prognosis;
- recommendation for treatment and/or placement.

009034(A)

Dr. Terry Swartz  
November 17, 1999  
Page Two

To assist you in locating these records, Mr. Moore's birthdate is 10/19/74 and his social security number is [REDACTED] His parents are Lee and Georgia Moore.

It is our understanding that Mr. Moore attended 4 – 6 counseling sessions with you during 1993. His mother was employed at General Motors at the time and is not certain what insurance covered the services.

In addition to our records request stated above please indicate the name of your agency's custodian of records, as it may be necessary to have the authenticity of the documents verified. Please forward this information to Ohio Public Defender, Attn: Jessica H. Love on or before November 27, 1999.

An authorization for release of all such records is enclosed for your files.

Sincerely,

Jessica H. Love  
Mitigation Specialist

JL/cw

Enclosure

#101631v1

009035

COMMUNITY DIAGNOSTIC AND TREATMENT CENTER

A Division of Central Psychiatric Clinic

909 Sycamore Street, Suite 300  
Cincinnati, Ohio 45202  
Phone: (513) 651-9300  
Fax: (513) 352-1345

WALTER S. SMITSON, PH.D.  
Executive Director

NANCY SCHMIDTGOESSLING, PH.D.  
Director

WILLIAM WALTERS, PH.D.  
Assistant Director

GAIL HELLMANN, M.D.  
Medical Director

MARILYN GEEDING, L.I.S.W.  
Treatment Coordinator

SHERRY SANDERS, L.P.C.C.  
Forensic Liaison

CHARLOTTE E. HOLLAND  
Office Manager

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MR. ARUN LAI

MR. THOMAS B. SCHERPENBERG

MR. DANIEL J. VALERIO

UNIVERSITY LIAISON

DONALD C. HARRISON, M.D.

JAMES RANDOLPH HILLARD, M.D.

September 1, 1994

Bethesda Hospital  
Attn: Dr. Schwartz  
619 Oak Street  
Cincinnati, Ohio 45206

RE: Lee Moore DOB: 10-19-74

TO WHOM IT MAY CONCERN:

Enclosed is a signed Authorization for Release of Information form regarding the above-named person.

Our agency is under a very strict time-frame to provide a comprehensive report to the Court, therefore, we would greatly appreciate information from you as soon as possible.

Thank you in advance for your prompt and courteous attention to this matter.

Sincerely,

*Jenny O'Donnell/yr*

Jenny O'Donnell, B.S.  
Psychology Trainee

009036

CENTRAL PSYCHIATRIC CLINIC  
COMMUNITY DIAGNOSTIC AND TREATMENT CENTER  
909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202  
513-651-9300

I, the undersigned, hereby authorize the Community Diagnostic and Treatment Center to release/obtain information from records pertaining to the person named below to/from the agency/person indicated. This authorization includes release of information concerning evaluation/treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV). All matters pertaining to client records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters cannot be given without the consent of the client. PROHIBITION ON REDISCLOSURE: Information disclosed or requested from records whose confidentiality is protected by Federal or State Law, may not be disclosed without the specific written consent of the person to whom it pertains.

AGENCY/PERSON Dr Schwartz @ Bethesda 1991 or 92

ADDRESS 619 Oak St., 45206

PURPOSE/NEED FOR DISCLOSURE of information between Community Diagnostic and Treatment Center and the agency/person named above: Aid in court-ordered evaluation/treatment of the person named below. OR

The following information may be released or reviewed:

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Discharge Summary                    | <input checked="" type="checkbox"/> Reports of Tests or X-rays |
| <input checked="" type="checkbox"/> Face Sheet with Final Diagnosis      | <input checked="" type="checkbox"/> Emergency Treatment(s)     |
| <input checked="" type="checkbox"/> Complications & Operative Procedures | <input type="checkbox"/> Outpatient Clinic Notes               |
| <input checked="" type="checkbox"/> History and Physical                 | Specify Clinic: <u>                    ?</u>                   |
| <input checked="" type="checkbox"/> Consultative Report(s)               | <input type="checkbox"/> Other <u>Medications?</u>             |
| <input type="checkbox"/> Inpatient                                       | <input type="checkbox"/> Emergency Department                  |
| <input checked="" type="checkbox"/> Outpatient                           |  |

This Authorization for Release of Information may be revoked by me at any time with written notice to the parties involved, except to the extent action has been taken prior to revocation. This Authorization for Release of Information will expire ninety (90) days after date below, or sooner by my choice, in which case this consent will expire on \_\_\_\_\_.

I hereby acknowledge that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the records to the purpose and extent stated above.

FULL NAME OF CLIENT Lee Moore

X Lee E. Moore  
(Signature of Client)

Date of Birth 10-19-74

Social Security No.                     

9-1-94  
(Date)

PLEASE FORWARD REQUESTED INFORMATION TO: Jenny O'Donnell  
Community Diagnostic and Treatment Center, 909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202.

This authorization was facilitated by Jenny O'Donnell  
(Staff member's signature)

Date 9-1-94

c: To be retained in Client Record

009037

LAW OFFICES

CHUCK R. STIDHAM  
CHRISTOPHER J. BERNARD

**SAND, STIDHAM AND BERNARD**

317 W. BENSON STREET  
READING, OHIO 45215  
(513) 761-4929  
FAX (513) 761-3573

\*ROBERT G. SAND  
(1932-1990)  
\*HARRY A. SAND  
(1922-1987)

July 22, 1994

Terry R. Schwartz, M.D.  
Bethesda Oak Hospital  
629 Oak  
Cincinnati, Ohio 45206

RE: Lee Edward Moore.  
D.O.B. - 10-19-74

Gentlemen:

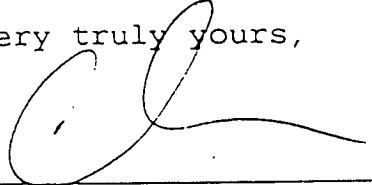
This office is handling the Mitigation Phase of the case pending in the Hamilton County Court of Common Pleas wherein Lee Edward Moore is facing a possible death sentence.

In an effort to present factors in mitigation to prevent the execution of Mr. Moore, I am attempting to compile as much of a personal history and background as possible. To this end, I have enclosed herein an Authorization and Release Form which permits you to release information concerning Mr. Moore's education to me. I would appreciate if you would have this information to me as quickly as possible.

I specifically need information concerning his treatment and condition.

I would appreciate if you would provide this information to me as quickly as possible as his Trial is scheduled to commence in the Hamilton County Court of Common Pleas in late August, 1994.

Very truly yours,

---

Chuck R. Stidham  
Attorney at Law

CRS/tas

Encl.

009038

Preferred  
Health Care

3/26/92

TERRY SCHWARTZ  
BETHESDA DOCTORS BLDG  
629 OAK ST, STE 600  
CINCINNATI, OH 45206

Dear TERRY SCHWARTZ:

Re: LEE MOORE

Preferred Health Care Ltd. (PHC), the Central Review Organization (CRO) for General Motors Corporation; determines the medical necessity of mental and health and substance abuse treatment and authorizes the payment of benefits for enrollees of General Motors/Connecticut General Health Benefit Plan, known as CARELINE.

This letter is in regard to the treatment of the above named patient. Based on a review of the information provided by the treating physician and/or other members of the treatment team, PHC has determined that treatment for the period from 3/30/92 to 5/01/92 meets PHC's national professional criteria for medical necessity.

06 UNITS FROM 03/30/92 THRU 05/01/92

Additional treatment beyond these dates, as well as specific services such as psychological testing, must be reviewed in advance before PHC will recommend payment. Therefore you must call 1-800-235-2302 for consideration of further authorization.

Please note that this letter does not guarantee payment for services. In addition to the Predetermination Requirement for reimbursement, payment depends on a number of factors including the enrollee's eligibility for coverage under the benefit plan, benefit plan limitations and the coordination of benefits with other plans. If you have questions about claims, please contact Connecticut General at 1-800-523-4626 (nationwide), 313-354-8330 (Detroit area).

Please call 1-800-235-2302 between the hours of 9:00 a.m. and 8:00 p.m., Eastern Standard Time if you have any questions.

Sincerely,

JUNE TRIPLETT  
Case Management Unit

[REDACTED] 2-B-0

cc:

009039



The Prudential Insurance Company of America  
P.O. Box 2850, Cincinnati, OH 45201-2850  
513-621-2884

From:

Terry R. Schwatz Psy.O.

Date:

02/24/92

Patient's Name:

Lee Moore

ID#:

## MENTAL HEALTH EVALUATION REPORT

Following the initial 2 evaluation visits, please submit the following information:

1. Multiaxial Diagnosis: 312.80 Conduct Disorder, low grades, caught with brass knuckles, lies, stays out late, sexually active, stubborn, skipping school
2. Target symptoms/signs/problems: antisocial behaviors, won't follow any rules at home or at school  
\* No background or history available or given
3. Specific goals for each target problem: Try to get limits and create some responsiveness to rules
4. Method of treating each problem: Behavioral, Cognitive Behavioral, unsuccessful
5. Time frame for achieving each goal: 3 months; Termination due to failure to reach him. Lee would not open up and discuss anything "Pulling Teeth"
6. Who is Provider treating each problem: [Signature]
7. Frequency of visits with each Provider: Total sessions  
02/24, 03/02, 03/11  
03/15, 03/25/92
8. Criteria for discharge from treatment: Client (Lee) was unresponsive he would not so much as utter a word, answered questions with "Yeah" or no, would not elaborate, terminated due to failure to reach him in any constructive ways.

Mail To: PruCare of Cincinnati  
P.O. Box 2850  
Cincinnati, Ohio 45201

- OVER -



54007  
54007  
880-000-0000

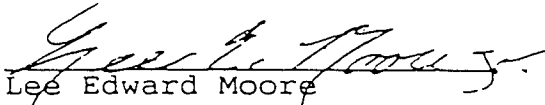
Dear Mr. Chuck Stridman:

I'm sorry I do not have anything more to offer. I have no other notes or records other than one sentence documenting Lee's unwillingness to talk or open up. I cannot make any more statements on background or history because I have none.

Respectfully,


JZG/10

I, LEE EDWARD MOORE, 1101 Clearbrook Drive, Cincinnati, Ohio 45229, hereby authorize you to release information concerning my health records to Chuck R. Stidham, Esq., Mitigation Specialists of Southwest Ohio, 317 W. Benson Street, Cincinnati, Ohio 45215.

  
Lee Edward Moore

STATE OF OHIO            )  
                                  ) SS:  
COUNTY OF HAMILTON)

Sworn to before me and subscribed in my presence by Lee Edward Moore on this 19 day of July, 1994.

  
\_\_\_\_\_  
Notary Public

CHUCK R. STIDHAM, Attorney at Law  
NOTARY PUBLIC - STATE OF OHIO  
My Commission has no expiration  
date. Section 147.03 O.R.C.

INSTRUCTIONS:

The top portion of the claim form is to be completed by the subscriber. The bottom portion is to be completed by the physician or supplier.

## PATIENT AND SUBSCRIBER INFORMATION (TO BE COMPLETED BY SUBSCRIBER)

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) <i>Noore, Lee</i>		2. PATIENT'S DATE OF BIRTH <i>10/18/74</i>	3. PATIENT L.D. NO. <i>[REDACTED]</i>
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) <i>1280 Meredith Dr Cinti Ohio 45231</i>		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) <i>Georgia Moore</i>
7. PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>		8. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) <i>Same</i>	
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICY HOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)		10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> B. ACCIDENT NO <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. <i>Signed: Georgia L. Moore</i> DATE		11. SUBSCRIBER'S EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP CODE) <i>G.M. Connecticut</i>	
		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGN PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW <i>Georgia L. Moore</i> SIGNED SUBSCRIBER OR AUTHORIZED PERSON DATE	

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMIT AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

## PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN OR SUPPLIER)

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)	18. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	19. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE <i>312.90</i>		20. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES				
22. A. DATE OF SERVICE FROM TO B. PLACE OF SERVICE C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (IF IN UNUSUAL SERVICE OR CIRCUMSTANCES) D. DIAGNOSIS CODE E. CHARGES						
1. INPATIENT HOSP.	<i>03/02/92</i>	<i>C</i>	<i>90844</i>	<i>Psychiatry</i>	<i>312.90</i>	<i>85.00</i>
2. OUTPATIENT HOSP.	<i>03/11/92</i>	<i>"</i>	<i>"</i>	<i>"</i>	<i>4</i>	<i>85.00</i>
3. DOCTOR'S OFFICE	<i>03/18/92</i>	<i>"</i>	<i>"</i>	<i>"</i>	<i>"</i>	<i>85.00</i>
4. HOME VISIT	<i>03/25/92</i>	<i>"</i>	<i>"</i>	<i>"</i>	<i>"</i>	<i>85.00</i>
5. SURG. CENTER'S OFFICE						
6. NURSING HOME						
7. WOE/END. LAB						
8. OTHER LOCATION						
9. SURGICAL CENTER						
23. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS). I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE <i>Terry R. Schwartz, Psy.D.</i>		24. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		25. TOTAL CHARGE <i>340.00</i>		26. AMOUNT PAID <i>0</i>
27. YOUR SOCIAL SECURITY NO. <i>[REDACTED]</i>		28. YOUR PATIENT'S ACCOUNT NO.		29. PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. <i>Terry R. Schwartz, Psy.D. Bethesda Oak Professional Center 629 Oak Street, Suite 600 Cincinnati, Ohio 45208</i>		30. BALANCE <i>340</i>
31. YOUR EMPLOYER I.D. NO.		32. YOUR OR LICENSE # <i>3528</i>				

Preferred Health Care Ltd.

2700 West 17th St. Suite 1000  
Cincinnati, OH 45204

Preferred  
Health Care

2/26/92

TERRY SCHWARTZ  
9462 HUNTERS CREEK  
CINCINNATI, OH 45242

Dear TERRY SCHWARTZ:

Re: LEE MOORE

Preferred Health Care Ltd. (PHC), the Central Review Organization (CRO) for General Motors Corporation, determines the medical necessity of mental and health and substance abuse treatment and authorizes the payment of benefits for enrollees of General Motors/Connecticut General Health Benefit Plan, known as CARELINE.

This letter is in regard to the treatment of the above named patient. Based on a review of the information provided by the treating physician and/or other members of the treatment team, PHC has determined that treatment for the period from 2/24/92 to 3/30/92 meets PHC's national professional criteria for medical necessity.

06 UNITS FROM 02/24/92 THRU 03/30/92

Additional treatment beyond these dates, as well as specific services such as psychological testing, must be reviewed in advance before PHC will recommend payment. Therefore you must call 1-800-235-2302 for consideration of further authorization.

Please note that this letter does not guarantee payment for services. In addition to the Predetermination Requirement for reimbursement, payment depends on a number of factors including the enrollee's eligibility for coverage under the benefit plan, benefit plan limitations and the coordination of benefits with other plans. If you have questions about claims, please contact Connecticut General at 1-800-523-4626 (nationwide), 313-354-8330 (Detroit area).

Please call 1-800-235-2302 between the hours of 9:00 a.m. and 8:00 p.m., Eastern Standard Time if you have any questions.

Sincerely,

TERRA SIMMONS/CSR  
Case Management Unit

S.S. #: [REDACTED] 2-B-0

cc: GEORGIA MOORE

009011

INSTRUCTIONS:

The top portion of the claim form is to be completed by the subscriber. The bottom portion is to be completed by the physician or supplier.

## PATIENT AND SUBSCRIBER INFORMATION (TO BE COMPLETED BY SUBSCRIBER)

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) <b>Noone, Lee</b>	2. PATIENT'S DATE OF BIRTH <b>10/19/74</b>	3. PATIENT L.D. NO. <b>[REDACTED]</b>
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) <b>1280 Meredith Dr Cinti Ohio 45231</b>	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) <b>Georgia Moore</b>
7. PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>	8. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) <b>Same</b>	9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICY HOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> B. ACCIDENT NO <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>	11. SUBSCRIBER'S EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP CODE) <b>G.M. Connecticut</b>	12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. SIGNED <b>x Georgia L. Moore</b> DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW <b>x Margaret Moore</b>		14. SIGNATURE OF SUBSCRIBER OR AUTHORIZED PERSON <b>[REDACTED]</b>

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMIT AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

## PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN OR SUPPLIER)

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) <b>3/2/90</b>	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)	18. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED <b>3/2/90</b> DISCHARGED <b>3/2/90</b>	19. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
20. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE <b>312.90</b>
22. PLACE OF SERVICE CODE 1. INPATIENT HOSP. 2. OUTPATIENT HOSP. 3. DOCTOR'S OFFICE 4. HOME VISIT 5. SURG. CENTER'S OFFICE 6. NURSING HOME 7. INDEPEND. LAB 8. OTHER LOCATION 9. SURGICAL CENTER	23. DATE OF SERVICE FROM <b>02/24/92</b> TO <b>03</b>	24. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY) <b>90894</b> (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) <b>Psychological Rx</b>
25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS). I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE <b>Terry R. Schwartz, Psy.D.</b>		26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
27. YOUR SOCIAL SECURITY NO. <b>[REDACTED]</b>		28. YOUR EMPLOYER I.D. NO. <b>[REDACTED]</b>
29. YOUR PATIENT'S ACCOUNT NO.		30. YOUR EMPLOYER I.D. NO.
31. TOTAL CHARGE <b>85.00</b>		32. AMOUNT PAID <b>00</b>
33. PHYSICIAN'S SUPPLIER'S AND OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. <b>Terry R. Schwartz, Psy.D. Bethesda Oak Professional Center 629 Oak Street, Suite 600 Cincinnati, Ohio 45208</b>		34. BALANCE <b>85.00</b>
35. OR LICENSE # <b>3528</b>		



Office of the Ohio Public Defender  
8 East Long Street  
Columbus, Ohio 43215-2998  
(614) 466-5394  
FAX NUMBER: (614) 752-5167

DAVID H. BODIKER  
State Public Defender

FAX HEADER

CAUTION - CONFIDENTIAL

THIS DOCUMENT IS BEING TELECOPIED TO YOU AND MAY CONTAIN INFORMATION PROTECTED BY ATTORNEY-CLIENT OR WORK PRODUCT PRIVILEGES.

This document which follows is only intended for the person to whom it is addressed. If you are not the intended recipient or authorized agent, then this is notice to you that dissemination, distribution or copying of this document is prohibited. If this document is received in error, please call the sender at once and destroy the document.

DATE: 11-8-99

TO: Brenda Green - 946-2730

FROM: Jessica H. Love - 800-686-1573

TOTAL NUMBER OF PAGES BEING FAXED (INCLUDING HEADER): \_\_\_\_\_

CONFIRM FAX RECEIVED TO: \_\_\_\_\_

RE: Any & All Information ON

Lee Edward Moore



Office of the Ohio Public Defender  
8 East Long Street  
Columbus, Ohio 43215-2998  
(614) 466-5394  
FAX NUMBER: (614) 723-3670

### AUTHORIZATION TO RELEASE INFORMATION

TO: Youth Center

RE: Lee E. Moore

2020 Auburn

Cincinnati, Oh

DATE: 11/8/99

ATTN: Brenda Green

You are hereby authorized to release to the Office of the Ohio Public Defender all records or other documents currently in your possession. Their representative may examine and make copies of all of my medical, psychological, hospital, police, and employment records, or any other records he/she may deem necessary in his/her work on my behalf. You are authorized to discuss these records and any other matters concerning me with said representative and are asked to assist him/her on the current investigation.

This authorization includes release of information concerning background, testing, and treatment of drug and alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV).

Lee E. Moore  
Client's Signature

WITNESS:

Jessica Fore



# Hamilton County Juvenile Court

## Youth Center

2020 Auburn Avenue  
CINCINNATI, OHIO 45219-3097  
(513) 946-2600

SYLVIA SIEVE HENDON, JUDGE  
(513) 852-8707  
(513) 852-3822 FAX

James C. Ray, Jr.  
Court Administrator  
(513) 852-8714  
(513) 852-8899 Fax

THOMAS R. LIPPS, JUDGE  
(513) 852-8712  
(513) 852-8550 FAX

Robert J. Dugan  
Superintendent  
(513) 946-2644  
(513) 946-2675 Fax

November 12, 1999

Jessica Love  
Office of the Ohio Public Defender  
8 East Long Street  
Columbus, Ohio 43215

Dear Ms. Love:

As a follow-up to our telephone conversations, according to computer records to which I have access personally, Lee Edward Moore (BD 10-19-74) was admitted and released from Detention on 8-12-92. As such, any medical records were destroyed according to Juvenile Court policy and no psychological reports were generated.

If I can be of further assistance or if you can provide me with other admission dates, please don't hesitate to call me at (513) 946-2636.

Sincerely,

A handwritten signature in cursive script that reads "Brenda L. Greene".

Brenda L. Greene, R.N.  
Certified Nurse Practitioner  
Medical Department

009048



**Office of the Ohio Public Defender**

8 East Long Street

Columbus, Ohio 43215-2998

(614) 466-5394

FAX NUMBER: (614) 644-9972

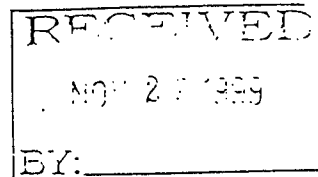
DAVID H. BODIKER

State Public Defender

430260  
M

November 24, 1999

Children's Hospital  
3333 Burnet Avenue  
Cincinnati, Ohio 45229

Attention: Medical RecordsRe: State of Ohio v. Lee E. Moore

Dear Sir/Madam:

Please be advised that the Ohio Public Defender is representing **Lee E. Moore** in the above referenced matter. The information requested herein is necessary for a detailed social history to be completed on his behalf.

In our efforts to properly represent **Mr. Moore** we are requesting that you provide us with any and all medical records regarding **Mr. Moore**. These records should include, but are not limited to:

MEDICAL

- admission and release dates;
- presenting problems, diagnoses, treatment plans
- and attending physicians' names'
- referrals, if applicable;
- prescriptions;
- testing and test outcomes including: X-rays,
- psychological evaluations, urine
- tests, blood tests, CAT scans, etc.

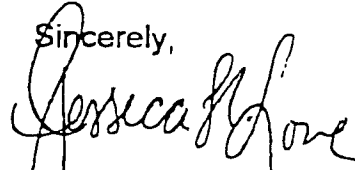
To assist you in locating these records, **Mr. Moore's** birthdate is 10/19/74 and his social security number is [REDACTED]. His parents are **Lee and Georgia Moore**.

Children's Hospital  
November 24, 1999  
Page Two

In addition to our records request stated above please indicate the name of your agency's custodian of records, as it may be necessary to have the authenticity of the documents verified. Please forward this information to Ohio Public Defender, Attn: Jessica H. Love on or before December 3, 1999.

An authorization for release of all such records is enclosed for your files.

Sincerely,



Jessica H. Love  
Mitigation Specialist

JL/cw

Enclosure

#102097v1

009050

**SMART****CORPORATION****Health Information Outsourcing Services**

Dear Requestor:

The enclosed health information was provided to you by Smart Corporation's health information outsourcing service. We are under agreement with the medical facility to release authorized copies of medical records. Smart will continue to copy records that you request from this facility.

If you have any questions regarding the enclosed records, please contact Smart Corporation's area office listed below:

Smart Corporation  
55 Union Street  
3<sup>rd</sup> Floor  
Boston, MA 02108  
800-448-6278

These photocopies have been made from the medical facility's original records. The confidentiality of these records is protected by federal and other law. These copies are intended exclusively for the requested purpose and cannot be recopied or redistributed for other purposes without the written informed consent of the person to whom it pertains.

- ( ) The \_\_\_\_\_ information you requested is not enclosed because it was not present in the medical record at the time we received your request.
- ( ) These records were reproduced from microfilm; their quality cannot be guaranteed.
- ( ) Your request for an itemized billing statement/x-ray films was forwarded to the appropriate department and will be sent under separate cover from that department.
- ( ) You requested all medical records. Please be advised, however, that this file contained some information that cannot be released without a specific patient authorization. Please contact the patient for such an authorization. If the patient has questions about the need for specific authorization, he or she must contact the medical records department of the facility.

If you would like more information about

**Smart Corporation's**

**Health Information  
Outsourcing Services**

for your medical facility, please complete  
the following and mail to:

Smart Corporation  
P.O. Box 1813  
Alpharetta, GA 30005  
Attn: Leah Rogers

Your Name \_\_\_\_\_

Title \_\_\_\_\_

Facility Name \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ # of Physicians \_\_\_\_\_

Specialty \_\_\_\_\_

# of Beds \_\_\_\_\_ # of Admits \_\_\_\_\_



Attention:

The following information is in accordance with Section 2317.422 of the revised Code of the Legislation of the State of Ohio, effective September 30, 1994.

I hereby certify that the attached data are true copies of the records requested on:

Patient Name: \_\_\_\_\_

Neer, Lee

Medical Record Number: \_\_\_\_\_

430260

These copies were reproduced from the original records prepared in the usual course of business of the Medical Records Department of Children's Hospital Medical Center on this date: 12/17/99.

If you have questions about the enclosed records, please contact our Correspondence Coordinator, Danita Carter at (513)-636-8233.

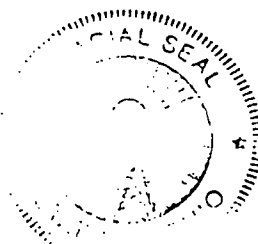
Sincerely,

Donna Krach, ART

Donna Krach, ART  
Assistant Director  
Medical Record Department

Subscribed and sworn to, in my presence, this

17th day of December



Taunya Renee Kessler  
TAUNYA RENEE KESSLER  
Notary Public, State of Ohio  
My Commission Expires \_\_\_\_\_